Todays
Date ________________

Dentistry *Today*

Thank you for choosing our practice! We welcome you and appreciate the confidence you place in us to provide dental services. To assist us in serving you, please complete the following form. The information you provide is **important for your overall health**. If there are changes in your health, at any later time, please be sure to update the information you have provided here today. If you have any questions, don't hesitate to ask. We are here for you and your wellness.

Patient name:________________________________ Date of Birth:____________ Age______ Sex_______

Home address:___________________________ City:____________________State_____ Zip___________

Billing address (if different): ____

Home Phone__________________________ Email ____

Cell Phone___________________________ Drivers License # _____________________ State _________

Work Phone__________________________ Employer (or School)_____________________________________

How do you prefer to be contacted? ☐ Home ☐ Cell ☐ Text ☐ Email ☐ Work

How did you hear about us?___________________________ Referred by______________________________

Emergency Contact ______________________________ Emergency Phone #_________________________

Patient's SS# ___________________________ ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Dental Insurance Company ____________________________ Ins Co Phone # _______________

Employer ____ Group #______________

Subscriber Name____ Subscriber #______________

Subscribers SS# __________________ Subscribers DOB _____________ Relationship to Pt ___________

Secondary Dental Insurance Company ____________________________ Ins Co Phone #
____

Employer ____ Group #______________

Subscriber Name____ Subscriber #______________

Subscribers SS# __________________ Subscribers DOB _____________ Relationship to Pt ___________

Please turn the page and complete the back side as well

To verify patient account and insurance information, please allow the patient coordinator to make copies of your **drivers license** and **dental insurance cards**. Thank you!

Medical Health History

Name of Medical Doctor_______________________ City _______________

Date of last visit to Medical doctor____________ What was that visit for?_______________

Name of Previous Dentist_______________________ City_______________

Date of last visit to Dentist____________ What was that visit for?_______________

Are you under a physicians care now? Y or N If so, what condition_______________
Are you taking any medications? Y or N If so, please list them_______________
Have you been hospitalized or had a major surgery? Y or N If so, describe_______________
Have you ever had a serious injury to your head or neck? Y or N If so, describe_______________

Are you allergic to any of the following?

Allergen		Allergen	
Local Anesthetics (Novocaine)	yes | no	Codeine, Demerol or other Narcotics	yes | no
Penicillin or other Antibiotics	yes | no	Sedatives, Barbiturates, Sleeping pills	yes | no
Sulfa drugs	yes | no	Metals	yes | no
Aspirin, Ibuprofen, Acetaminophen	yes | no	Latex	yes | no

Please list any other allergies _______________

WOMEN: Are you pregnant or trying to become pregnant? Y or N
Are you nursing? Y or N
Do you take Oral Contraceptives? Y or N Note: Many antibiotics make contraceptives INEFFECTIVE

Do you have or have you ever had any of the following?

Condition		Condition		Condition		Condition	
Heart murmur	yes | no	Blood Disease	yes | no	Breathing Problem	yes | no	Renal Dialysis	yes | no
Mitral Valve Prolapse (MVP)	yes | no	Unexplained Fever	yes | no	Asthma	yes | no	Thyroid Disease	yes | no
Rheumatic Fever	yes | no	Bruise Easily	yes | no	Emphysema	yes | no	Stroke	yes | no
Scarlet Fever	yes | no	Excessive Bleeding	yes | no	Tuberculosis	yes | no	Epilepsy or Seizures	yes | no
Artificial Heart valve	yes | no	Leukemia	yes | no	Frequent Cough	yes | no	Fainting or Dizziness	yes | no
Pace Maker	yes | no	Blood Transfusion	yes | no	Bloody Sputum	yes | no	Convulsions	yes | no
Heart trouble/Disease	yes | no	Coumadin	yes | no	Diabetes	yes | no	Alzheimer's Disease	yes | no
Angina/Chest Pain	yes | no	Plavix	yes | no	Excessive Thirst	yes | no	Glaucoma	yes | no
Heart Attack/Failure	yes | no	Daily Aspirin	yes | no	Urinate more than 6x per day	yes | no	Nervousness	yes | no
Irregular Heart Beat	yes | no	High Blood Pressure	yes | no	Hypoglycemia	yes | no	Radiation Treatment	yes | no
Congenital Heart Disorder	yes | no	Anemia	yes | no	Liver Disease	yes | no	Chemotherapy	yes | no
Heart Surgery	yes | no	Hemophillia/ Blood	yes | no	Hepatitis A Infection	yes | no	Cancer	yes | no
Low Blood Pressure	yes | no	Shortness of Breath	yes | no	Hepatitis B or C Infection	yes | no	Tumors or Growths	yes | no
High Blood Pressure	yes | no	Lung Disease	yes | no	Yellow Jaundice	yes | no	Swelling of Limbs	yes | no
Stomach Disease	yes | no	Arthritis/Gout	yes | no	Cortisone Medicine	yes | no	Drug Addiction	yes | no
Intestinal Disease	yes | no	Rheumatism	yes | no	Hay Fever	yes | no	Tattoos	yes | no
Ulcers	yes | no	Latex sensitivity	yes | no	Sinus Trouble	yes | no	Venereal Disease	yes | no
Recent Weight Loss	yes | no	Allergies (Medicines)	yes | no	Cold Sores	yes | no	HIV Positive	yes | no
Frequent Diarrhea	yes | no	Allergies (Pollen, Dust)	yes | no	Fever Blisters	yes | no	HIV Infection	yes | no
Night Sweats	yes | no	Hives or Rash	yes | no	Herpes	yes | no	AIDS	yes | no
Take PreMedication before Dental procedures	yes | no	Artificial joints, hip or knee	yes | no				

Have you tested for COVID 19 in the last 14 days? Yes / No If Yes, where/when/results of testing?_______________

Have you had any symptoms of any illness in the last 2 weeks? Yes / No If Yes, what symptoms?_______________

Have you been in contact with anyone that was sick in the last 2 weeks? Yes / No If Yes, how long ago was the exposure?________

Dental Health History

Why have you come to see us today? ______________________________

Do you have dental examinations on a routine basis? Y or N Date of Last Dental Visit?______________________

Are you apprehensive about dental treatment? Y or N If yes, explain______________________________

Circle One: How often do you brush? Twice a Day Daily Every Other Day Weekly Monthly Never

How often do you floss? Twice a Day Daily Every Other Day Weekly Monthly Never

Do you avoid brushing or flossing any part of your mouth? Y or N If yes, explain______________________

Do you use fluoride supplements in addition to that in toothpaste? Y or N If yes, which one(s)?__________________

Do your gums bleed when you brush or floss? Y or N If yes, during which one?______________

Do you gums feel swollen or tender? Y or N

Do you have any loose teeth? Y or N If yes, which one(s)?______________________

Does food catch between your teeth? Y or N

Have you noticed any mouth odors or bad tastes? Y or N

Do you have difficulty chewing your food? Y or N

Do you chew on one side of your mouth? Y or N

Do you feel twinges of pain to hot or cold? Y or N If yes, explain______________________________

Do you clench or grind your teeth in the daytime? Y or N

Do you clench or grind your teeth at night that you're aware of? Y or N

Do your jaws ever feel tired or sore? Y or N
If yes, please explain______________________________

Has your jaws ever become stuck (open or closed)? Y or N If yes, please explain______________________

Do your jaws hurt when chewing or opening wide? Y or N

Do you have jaw pain or discomfort around your ears or headaches upon awakening? Y or N

Have you had any intense hits to the mouth or jaws in your life? Y or N
If yes, please describe______________________________

Do you smoke or use tobacco of any kind? Y or N If yes, which tobacco products?______________________

Are you dissatisfied with the look of your teeth? Y or N If yes, explain__________________

Do you want whiter teeth? Y or N

By signing below, I certify that I have answered the questions above to the best of my ability and knowledge, and that all answers are true and accurate concerning my personal, medical. and dental health.

Signature ______________________________

Please return all attached documents to the concierge desk, thank you

Welcome to our practice! It is our desire to make high quality dental care affordable to everyone. The following is a statement of our office policy and financial policy, which we ask that you **read**, agree to, and sign before any treatment is rendered.

Minors

The **adult** accompanying a minor **is responsible** for full payment and the signing of this document. For unaccompanied minors, treatment will be denied, unless this document and authorization for treatment and the associated fees have been preauthorized from the parent or legal guardian.

Initial ____________________

Cancellation Policy

If you are unable to keep and an appointment, we ask that you kindly provide us with a minimum of 48 hours notice. Our office does not accept cancellation or changes in appointments after-hours by voicemail; you must call during business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist.

Initial ____________________

Missed Appointment Fee

Missed appointment fee of $35 will be charged to any patient who does not notify our office within 24 hours to cancel or reschedule their appointment.

Initial ____________________

Dental Insurance

I understand my dental insurance is a contract between myself and my insurance carrier, not between Dentistry Today doctors and the insurance carrier.

We, Dentistry Today providers, must emphasize that as dental care providers, our relationship is with you, not your insurance company. Treatment recommended by our office is never based on what your insurance will pay. It is based on the professional opinion of your oral condition by your dental caregiver. Your treatment recommendations should not be governed by your or our insurance contracts.

CoPays

Please note that **NO individual in this office can predict exactly what amount your insurance will pay.** When we verify your coverage with your insurance company, they also indicate that there is no guarantee of coverage, until they receive the claim. We will only be able to give you an estimate and we cannot be held responsible to that estimate in any way.

**Initial ____________________

Payment at Time of Service

Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient/guarantor is responsible for the ***estimated portion*** of the fee that the insurance does not cover. Please be aware that this initial payment is an **estimate** based on your individual plan and that it is **NOT** meant to indicate what your insurance will or will not pay. Any remaining balance after insurance pays on a claim, is the patients responsibility.

I understand that I, the **patient/guarantor am responsible for all charges that are denied or unpaid by my insurance carrier.**

**Initial ____________________

Insurance Processing Time

Insurance has 30 days to act on each claim by law. If for some reason your insurance carrier has not made payment within 45 days, the patient/guarantor is responsible for any remaining balance, regardless of the reason. We will continue to help you in any way to obtain reimbursement on a claim. Any payment that may be received in this office from insurance after that time and after the balance has been satisfied, will be returned to you or applied as a credit on your account, whichever you prefer.

I understand that after 45 days from the date of service, I am responsible for any remaining balance.

**Initial ____________________

Annual Maximums

All dental insurance plans have annual limits and/or various degrees of patient co-payments. If and when the patient reaches their insurance maximum, it is the **patient's/guarantor's responsibility to be aware of it and provide the information**. If this information is not provided, the patient/guarantor will be responsible for all charges incurred. The amount paid out by your insurance is provided to you, the patient, by mail to your home, upon payment of each claim. When the total of these payments approaches your annual maximum, please be aware of it and you must inform our office.

**Initial ____________________

Past Due Accounts

I understand that I am financially responsible for all charges incurred in full for myself and /or my dependents. I agree that in the event my account is past due sixty (60) days from the date of service, it will be turned over to collection agency unless arrangements are made in advance. Monthly interest rate of 1.5% (18% APR) will be incurred for accounts sixty (60) days past-due. I agree that I am liable for all collection charges, including but not limited to attorney and legal fees in the event my account was turned over to collection agency. A fee of $35 will be charged on all returned checks.

Initial ____________________

Authorization To Treat

I give the doctors at Dentistry Today the authority to administer any treatments necessary for my dental care and health, which includes, but is not limited to, dental x-rays, local injections, and anesthetics. *If I* have a medical condition that requires premedication, or drug allergy, I acknowledge that it is my

responsibility to inform the Doctors, Assistant, and the Hygienist every visit before treatment. Please advise our office of ANY and ALL medications you may be taking - especially any antibiotics or blood thinners (Aspirin on a daily basis, Plavix or Coumadin).

Initial ____________________

Authorization to Use and/or Disclose Healthcare Information

I authorize Dentistry Today, Inc and its doctors to use and/or disclose my healthcare information for the purposes of providing the highest quality dental care as well as to obtain insurance benefits for me from my insurance company.

Initial ____________________

PPPP
I have read, understand, and agree to the above Office Policies.

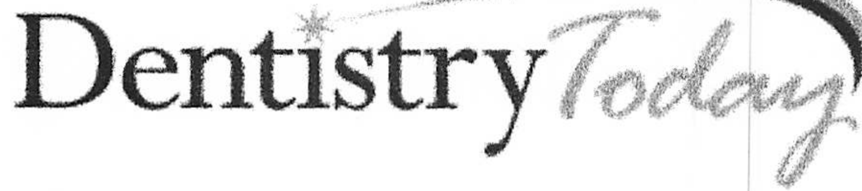
Patient Name:____

Patient Signature:____

Parent Signature, (if patient is a minor)____

Date:____

Witness:____



HIPPA Release of Information Authorization Form

I, ______________________________ hereby authorize Dentistry Today and its affiliates, its employee and agents to release my personal health information including but not limited to information relating to the diagnosis, treatment, claims payment, and health care services provider to be provided to me and which identifies my name, address, social security number, member ID number.

I understand that any personal dental information or other information released to the referred physician or organization may be subject to re-disclosure and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to Dentistry Today within 30 days. However, this authorization may not be revoked if Dentistry Today, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Member: (Patient) Print: ______________________________

Signature of Member: ______________________________

Date: ________________